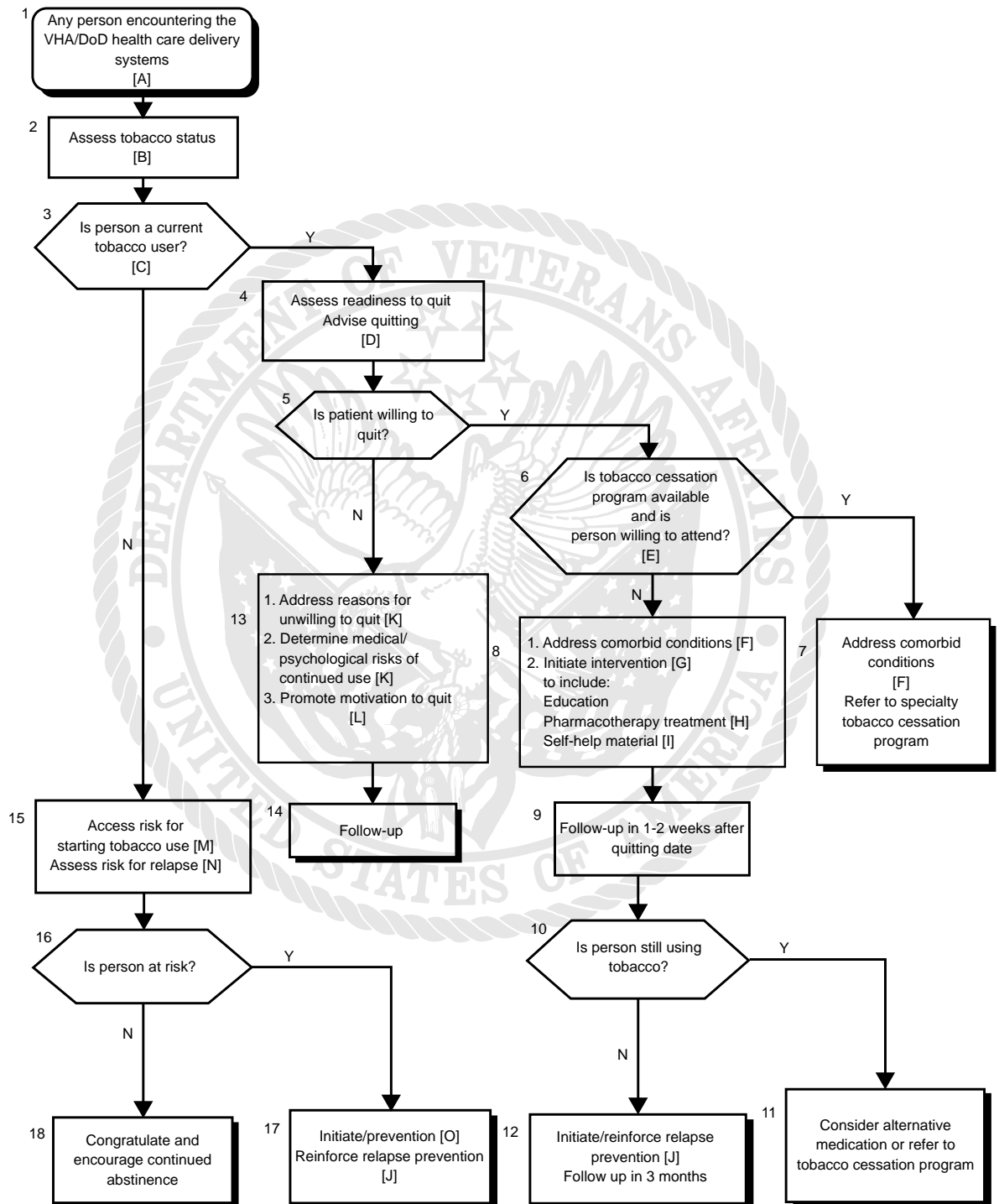


VA/DoD Clinical Practice Guideline for Promotion of Tobacco Use Cessation (TUC)

Guideline Summary



VA access to full guideline: <http://vaww.oqp.med.va.gov>

DoD access to full guideline: <http://www.cs.amedd.army.mil/Qmo>

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Summary The single most important step in addressing tobacco use and dependence is screening for tobacco use. After the clinician has asked about tobacco use and has assessed the willingness to quit, he or she can then provide the appropriate intervention, either by assisting the patient in quitting using the "5 A's" (Ask, Advise, Assess, Assist, and Arrange) or by providing a motivational intervention using the "4 R's" motivational intervention (Relevance, Risks, Rewards, and Repetition). Patients who have recently quit using tobacco should be provided relapse prevention treatment (Congratulations and Encouragement).

Performance Measures/Metrics

1. Percentage of patients screened annually for tobacco use
2. If current user of tobacco, advised of health risks and offered tobacco cessation counseling at least 3 times each year
3. Percentage of patients who currently do not use tobacco

Key Findings

The guideline identifies a number of key findings that clinicians should utilize:

1. Tobacco dependence is a chronic condition that often requires repeated intervention. However, effective treatments exist that can produce long-term or even permanent abstinence.
 2. Brief tobacco dependence treatment is effective. Every patient who uses tobacco should be offered at least one of these treatments:
 - Patients willing to try to quit tobacco use should be provided with treatments below that are identified as effective in the guideline.
 - Provision of practical counseling (problem solving/skills training);
 - Provision of social support as part of treatment (intra-treatment social support); and
 - Help in securing social support outside of treatment (extra-treatment social support).
 - Patients unwilling to try to quit tobacco use should be provided with a brief intervention that is designed to increase their motivation to quit.
 3. It is essential that clinicians and health care delivery systems (including administrators, insurers, and purchasers) institutionalize the consistent identification, documentation, and treatment of every tobacco user who is seen in a health care setting.
 4. There is a strong dose-response relationship between the intensity of tobacco dependence counseling and its effectiveness. Treatments involving person-to-person contact (e.g., individual, group, or proactive telephone counseling) are consistently effective, and their effectiveness increases with treatment intensity (e.g., minutes of contact).
 5. Counseling and behavioral therapies were found to be especially effective and should be used with all patients who are attempting tobacco cessation.
 6. Numerous effective pharmacotherapies for smoking cessation now exist. Except in the presence of contraindications, these should be used with all patients who are attempting to quit smoking.
 - The following first-line pharmacotherapies are reliable in increasing long-term smoking abstinence rates:
 - Bupropion SR
 - Nicotine gum
 - Nicotine inhaler
 - Nicotine nasal spray
 - Nicotine patch
- NOTE. Over-the-counter nicotine patches are effective relative to placebo.

The 5 A's

Ask—Systematically Identify All Tobacco Users at Every Visit

- Systematically identify all tobacco users at every visit.
- Status of tobacco use (current, former, never)

Advise—Strongly Urge All Tobacco Users to Quit

- In a clear strong and personalized manner, urge all tobacco users to quit.
- Tie tobacco use to current health costs and family impact.

Assess—Determine Willingness to Make a Quit Attempt

- Ask every tobacco user if he or she is willing to make a quit attempt at this time. See DSM-IV criteria for addiction and assessment of nicotine dependence and withdrawal symptoms of DSM-IV.

Nicotine Addiction Assessment. *Nicotine withdrawal syndrome: A characteristic set of symptoms that develops after the abrupt cessation or a reduction in the use of nicotine products after at least several weeks of daily use and is accompanied by four of the following signs and symptoms: dysphoria or depressed mood; insomnia; irritability; frustration or anger; anxiety; difficulty concentrating; restlessness or impatience; decreased heart rate; increased appetite or weight gain. NOTE: withdrawal symptoms must also cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, and must not be secondary to a general medical condition or be accounted for by another mental disorder.*

- Review tobacco use history-type, quantity and tobacco use frequency.

Willing: Refer to TUC program or office-based TUC program.

Unwilling: Motivate

- Review hazards of use using a personalized message related to:

- Benefits of quitting
- Available medical options
- Risk/Special populations
 - Adolescent
 - Pregnancy
 - Co-morbid illness (physical/mental)
- Multiple quit attempts/Relapse

Assist—Aid the Patient in Quitting

- Aid the patient in quitting
 - Referral to existing TUC program
 - Initiate office-based program
 - Offer pharmacotherapy

- Help the patient with a quit plan

- A patient's preparations for quitting:

Set a *quit* date—ideally, the quit date should be within 2 weeks.

Tell family, friends, and coworkers about quitting and request understanding and support.

Anticipate challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.

Remove tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, and car).

Arrange—Schedule Follow-up Contact

Schedule follow-up contact, either in person or via telephone.

Timing—Follow-up contact should occur soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated.

Actions during follow-up contact—Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience.

Identify problems already encountered and anticipate challenges in the immediate future. Assess pharmacotherapy use and problems. Consider use or referral to more intensive treatment.

- Provide practical counseling (problem solving/training).
 - Recognize danger situations—Identify events, internal states, or activities that increase the risk of smoking or relapse.
 - Negative affect.
 - Being around other smokers.
 - Drinking alcohol.
 - Experiencing urges.
 - *Develop coping skills*—Identify and practice coping or problem solving skills. Typically, these skills are intended to cope with danger situations.
 - Learning to anticipate and avoid temptation.
 - Learning cognitive strategies that will reduce negative moods.
 - Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure.
 - Review past quit attempts including identification of what helped during the quit attempt and what factors contributed to relapse
 - *Provide basic information*—Provide basic information about smoking and successful quitting.
 - Withdrawal typically peaks within 1-3 weeks after quitting.
 - The addictive nature of smoking.
- Provide intra-treatment social support.
 - Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. "My staff and I are available to assist you."
 - Encourage the patient in the quit attempt.
 - Note that effective tobacco dependence treatments are now available.
 - Communicate belief in patient's ability to quit.
 - Communicate caring and concern.
 - Ask how patient feels about quitting.
 - Directly express concern and willingness to help.
 - Be open to the patient's expression of fears of quitting, difficulties experienced, and ambivalent feelings.
 - Encourage the patient to talk about the quitting process.
 - Ask about:
 - Reasons the patient wants to quit.
 - Concerns or worries about quitting.
 - Success the patient has achieved.
- Help patient obtain extra-treatment social support.
 - Help patient develop social support for his or her quit attempt in his or her environments outside of treatment. "Ask your spouse/partner, friends, and coworkers to support you in your quit attempt."
 - Anticipate triggers or challenges in upcoming attempt-discuss challenges/triggers and how patient will successfully overcome them. Examples: job stresses, spouse smoking, life changes, alcohol use, etc.
 - Aid patient in establishing a smoke-free home.
 - Prompt support seeking.
 - Help patient identify supportive others.
 - Call the patient to remind him or her to seek support.
 - Inform patients of community resources such as hotlines and helplines.
- Recommend the use of approved pharmacotherapy, except in special circumstances.
 - Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.

Pharmacotherapy Considerations for Tobacco Use Cessation

Who should receive?

All tobacco users trying to quit except:

Medical contraindications

Non-nicotine dependent

Pregnant

Adolescents

Concerned about weight gain?

Bupropion SR and nicotine replacement therapies, in particular nicotine gum, have been shown to delay, but not prevent, weight gain.

Who should be considered for long-term pharmacotherapy (e.g., greater than 3 months)?

Those with persistent withdrawal symptoms.

Those who desire long-term therapy (shared decision with provider).

No long term health risk.

Use of these medications long term does not present a known health risk.

Suggestions for the Clinical Use of Pharmacotherapies for Smoking Cessation

Nicotine replacement products		
Transdermal nicotine		
Dosage	Heavy dependence	> 24 cigarettes/day-High dose (21 mg) for 6 weeks, then intermediate does (14 mg) for 2 weeks, then low dose (7 mg) for 2 weeks
	Mild dependence	< 24 cigarettes/day-Intermediate dose (14 mg) for 6 weeks, then low dose (7 mg) for 2 weeks Taper over 2 weeks
Contraindications	Allergy, pregnancy (Risk Category D)	
Adverse reactions	Sleep disturbances, skin irritations	
Drug Interactions	No direct interactions; smoking cessation may alter the pharmacokinetics of some drugs	
Polacrilex nicotine		
Dosage	> 25 cigarettes/day; 4 mg strength < 25 cigarettes/day; 2 mg strength One piece of gum q 1 to 2 hr for 6 weeks Taper over 6 weeks	
Contraindications Adverse	Allergy; pregnancy (Risk Category C)	
Reactions	Nausea, dyspepsia, jaw fatigue, dependency	
Drug Interactions	No direct interactions; smoking cessation may alter the pharmacokinetics of some drugs	
Nasal spray nicotine		
Dosage	8 to 40 mg/day (average 15 mg) for 8 weeks Taper over 6 weeks	
Contraindications	Allergy; pregnancy (Risk Category D)	
Adverse Reactions	Nasal and/or throat irritation, dependence	

Drug Interactions	No direct interactions; smoking cessation may alter the pharmacokinetics of some drugs
Oral vapor nicotine-inhaler	
Dosage	6 to 16 cartridge/day for 12 weeks (each cartridge is 4 mg) Taper over 6 to 2 weeks
Contraindications	Allergy; pregnancy (Pregnancy Category D)
Adverse Reactions	Mouth and throat irritation, dependence
Drug Interactions	No direct interactions; smoking cessation may alter the pharmacokinetics of some drugs
Non-nicotine tobacco cessation product	
	Bupropion SR
Dosage	150 mg qd for 3 days, then 150 mg bid for 7 to 12 weeks
Contraindications	Seizure disorders, predisposition to seizures, MAOIs, allergy (Pregnancy Category B)
Adverse Reactions	Sleep disturbances, dry mouth
Drug Interactions	Selected antidepressants (MAOIs, norepinephrine re-uptake inhibitors), drugs metabolized by CYP2B6 and CYP2D6

Pregnancy Categories Rate:

A - Adequate studies in pregnant women have failed to show a risk to the fetus.

B - Animal studies have not shown a risk to the fetus, but controlled studies have not been conducted in pregnant women; or animal studies have shown an adverse effect on the fetus, but adequate studies in pregnant women have not shown a risk to the fetus.

C - Animal studies have shown an adverse effect on the fetus, but adequate studies have not been conducted in humans.

The benefits from use in pregnant women may be acceptable despite potential risks.

D - The drug may cause risk to the human fetus, but the potential benefits of use in pregnant women may be acceptable despite the risks.

X - Studies in animals or humans show fetal abnormalities, or adverse reaction reports indicate evidence of fetal risk. The risks involved clearly outweigh potential benefits.

NR - Not rated.

All these medications should be cleared through *military/civilian special authority*.

Proper Use of Nicotine Replacement Therapy

Gum: Persons should be instructed to chew the gum until a mild tingling or peppery taste is felt in the gums. The gum should then be "parked" in the buccal mucosa until the tingling subsides. Alternate slow and intermittent chewing and parking the gum for about 30 minutes.

Spray: A single dose consists of 1 spray in each nostril. The usual adult dose is 1 to 2 sprays/hour, to a maximum of 5 sprays an hour or 40 sprays a day. Persons should be cautioned not to exceed recommended doses, and to be aware of the potential for dependence that may result from use of this product.

Patch: Place a new patch on a hairless area between the neck and waist or inner arm at start of each day. Rotate the site of administration to minimize skin irritation.

Inhaler: The "inhaler" is actually a puffer, which consists of cotton impregnated with nicotine enclosed in a small capsule, which the delivery device punctures on closure. When the user puffs on the device (which resembles a cigarette holder), vaporized nicotine is delivered to the mucosa of the mouth and posterior pharynx, where it is absorbed. About 80 puffs are required over 20 minutes to obtain 2mg of nicotine (about half the maximum deliverable amount available in each capsule). Persons should be told to stop smoking completely before using this product, and not to exceed the recommended maximum dosage (16 mg/day).

Tobacco Users Unwilling to Quit

The "4R's," *Relevance*, *Risk*, *Rewards*, *Roadblocks*, and *Repetition*, are designed to motivate smokers who are unwilling to quit at this time.

Relevance

Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).

Risks

The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:

- Acute risks: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, and increased serum carbon monoxide.
- Long-term risks: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability, and need for extended care.
- Environmental risks: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking in children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards

The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:

- Improved health.
- Improved sense of smell and taste.
- Save money.
- Home, car, clothing, breath will smell better.
- Set a good example for children.
- Have healthier babies and children.
- Not worry about exposing others to smoke.
- Feel better physically.
- Perform better in physical activities.
- Reduced wrinkling/aging of skin.

Repetition

The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Former Smokers-Preventing Relapse

Most relapses occur soon after a person quits smoking, yet some people relapse months or even years after the quit date. All clinicians should work to prevent relapse. Relapse prevention programs can take the form of either minimal (brief) or prescription (more intensive) programs.

Components of Minimal Practice Relapse Prevention

These interventions should be part of every encounter with a patient who has quit recently. Every ex-tobacco user undergoing relapse prevention should receive congratulations on any success and strong encouragement to remain abstinent. When encountering a recent quitter, use open-ended questions designed to initiate patient problem solving

(e.g., How has stopping tobacco use helped you?). The clinician should encourage the patient's *active* discussion of the topics below:

- The benefits, including potential health benefits, that the patient may derive from cessation.
- Any success the patient has had in quitting (duration of abstinence, reduction in withdrawal, etc.).
- The problems encountered or anticipated threats to maintaining abstinence (e.g., depression, weight gain, alcohol, other tobacco users in the household).

Components of Prescriptive Relapse Prevention

During prescriptive relapse prevention, a patient might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by patients and potential responses follow:

Lack of support for cessation

- Schedule follow-up visits or telephone calls with the patient.
- Help the patient identify sources of support within his or her environment.
- Refer the patient to an appropriate organization that offers cessation counseling or support.

Negative mood or depression

- If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.

Strong or prolonged withdrawal symptoms

- If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacotherapy or adding/combining pharmacologic medication to reduce strong withdrawal symptoms.

Weight gain

- Recommend starting or increasing physical activity; discourage strict dieting.
- Reassure the patient that some weight gain after quitting is common and appears to be self-limiting.
- Emphasize the importance of a healthy diet.
- Refer the patient to a specialist or program.

Flagging motivation/feeling deprived

- Reassure the patient these feelings are common.
- Recommend rewarding activities.
- Probe to ensure that the patient is not engaged in periodic tobacco use.
- Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

Additional resources:

The Surgeon General's Web Site: www.surgeongeneral.gov/tobacco/default.htm

Conclusion

Primary care providers cannot do this work by themselves. They need support!